



****DO NOT USE CORRECTION FLUID****

AmeriCorps CARE CAREGIVER INFORMATION AND REGISTRATION FORM
PLEASE PRINT CLEARLY !!!!THIS SIDE TO BE COMPLETED BY CAREGIVER ONLY!!!!

Caregiver's Name _____

Date of Birth ____/____/____

(As it will appear on checks and on coupons):

Caregiver's Mailing Address:

Address where care is to be provided:

What county is this address in: _____

What is your telephone number? (____)____-____

YOU MUST COMPLETE THIS SECTION:

SSN # (if you are unlicensed/unregulated): ____-____-____ (ATTACH A COPY OF SOCIAL SECURITY CARD)

OR Fed ID # ____-____-____ (ATTACH A COPY OF LICENSE OR REGISTRATION)

Check as appropriate: Type of Care: FDC (Family Day Care Home) ____ Center ____

Group Home ____ Unlicensed/Unregulated ____

Regulatory Status: Licensed/Regulated ____ Exempt (i.e. family member, friend) ** ____

Child Care License No./Registration No. (If applicable): _____

Licensing Contact Name and Phone Number: _____ (____)____-____

****YOU MUST MEET STATE GUIDELINES TO BE CONSIDERED LEGALLY EXEMPT; contact AMERICORPS CARE or your state licensing agency for more information.**

Date Care Begins: ____/____/____ **Date Care Ended (if applicable):** ____/____/____ **Member's Name:** _____

NAMES OF CHILDREN TO BE CARED FOR THROUGH AMERICORPS CARE

Member's Child(ren) In Your Care	SSN (must be filled in)	Date of Birth	Gender (M/F)	Relationship to Caregiver
1.	- -			
2.	- -			
3.	- -			
4.	- -			

Member's Child(ren) In Your Care	Period of Care (✓)							Hours Children In Care From To
	SUN	MON	TUE	WED	THU	FRI	SAT	
1.								
2.								
3.								
4.								

To be completed by Family Day Care Homes, Group Day Care Homes, and Unlicensed/Unregulated Individuals Only:

Please list the total number of children in your care and relationship to you, if applicable. Total # of Children in Your Care: _____

Child:

Relationship:

AMERICORPS CARE Caregiver Information Registration Form (cont.)

CAREGIVER RESPONSIBILITIES AND CERTIFICATION

1. Caregiver will continue to meet all minimum requirements set by the state and agrees to comply with all AMERICORPS CARE policies necessary for reimbursement.
2. Caregiver will notify AMERICORPS CARE immediately when a child ceases to receive care. It is understood that any parent must be given access to his/her child(ren) at any time during care hours.
3. Caregiver will mail the monthly coupon/attendance sheet **NO LATER THAN the first (1st) day** of the month following care or upon termination of care (if care stops before the end of the month). **PLEASE NOTE:** Reimbursement may be delayed if the childcare coupon is postmarked later than the 1st day of the month following care. In addition, 24-hour or overnight care may not be legal in all states.
4. Caregiver will not charge a higher fee for children of AMERICORPS Members than for the same service to the public. **NOTE: Failure to adhere to this policy will result in caregiver being required to refund overpayments and in cancellation of this and future payments from AMERICORPS CARE.**
5. **AMERICORPS CARE** will not pay additional fees for registration, late, transportation, meals, snacks, trips (ie., fieldtrips, etc.) or any other miscellaneous fees. Caregiver shall collect any such fees directly from the Member.
6. Caregiver agrees to repay **AMERICORPS CARE** any money received for which services were not provided.
7. Caregiver agrees to notify **AMERICORPS CARE** at least fifteen (15) calendar days before ending childcare services. **NOTE: In cases of emergency please notify AMERICORPS CARE immediately (1.800.570.4543).**

The AMERICORPS Member has chosen you to provide childcare services. Prior to reimbursement, you must first provide all information requested on the front of this form, be determined a legal caregiver in your state, and the member must be determined and remain eligible to receive childcare benefits through **AMERICORPS CARE**.

Caregiver Signature

_____/_____/_____
Date

AMERICORPS CARE RESPONSIBILITIES

1. AMERICORPS CARE is responsible for coordination of childcare allowance and other related support services as necessary to the children and families served under this agreement.
2. AMERICORPS CARE will pay only pay licensed and regulated caregivers for federal holidays and school vacations. AMERICORPS CARE will also pay licensed and regulated caregivers for up to five sick/no-care days per month. Excessive absences may require formal documentation (ie., doctor's note).
3. AMERICORPS CARE will not pay more than one caregiver, for the same child (ren), for the same period of care.

PARENT RESPONSIBILITIES AND CERTIFICATION

I [the member] understand that:

1. Childcare benefits for which I am eligible are based on my income, family size, age of child(ren), the caregiver's location, and the type of child care I select and that if there are any changes to my situation, **I must make both my State Program Officer and AMERICORPS CARE aware of those changes.**
2. I agree to complete the necessary documents (ie., childcare coupons) on a timely basis, to ensure the caregiver may receive timely reimbursement.
3. I agree to submit proof of my continued eligibility for this program when requested.
4. I agree to notify AMERICORPS CARE at least fifteen (15) calendar days before ending childcare services. In cases of emergency please notify AMERICORPS CARE immediately (1.800.570.4543).
5. I understand that the caregiver indicated on page 1 of this form must meet all state requirements to provide childcare services, and that AMERICORPS CARE is under no obligation to begin reimbursements before the caregiver has been determined legal.

I have read this agreement and understand that failure to comply with the terms of this agreement may result in the termination of my childcare benefits.

AMERICORPS Member Signature

_____/_____/_____
Date

!!!!MEMBER: PLEASE FORWARD THIS AND ALL CHILDCARE FORMS TO YOUR STATE PROGRAM OFFICER FOR SIGNATURES!!!!

PROGRAM DIRECTOR CERTIFICATION

I certify that the Member requiring childcare services as per this agreement is a full-time AMERICORPS Member and is eligible for childcare benefits through AMERICORPS CARE. I authorize that funds designated for childcare be made available to AMERICORPS CARE for regular payment of services as described above.

Program Director's Name

Program Director's Signature

_____/_____/_____
Date